K&K INSURANCE

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HARTFORD LIFE INSURANCE COMPANY
STUDENT OR ATHLETE ACCIDENT CLAIM FORM
KENTUCKY K-12 ACCOUNTS

File your claim promptly. Failure to do so could result in a denial of coverage.

INSTRUCTIONS FOR FILING

(NOTE: Claim Form must be fully completed and signed.)

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form, attach all related medical bills and explanation of benefits and forward to K&K Insurance Group.

To the Student or Athlete/Parent/Guardian

Attach current itemized physician, hospital, or other provider's bills for accident medical expenses being claimed as well as the primary carrier's Explanation of Benefits showing it's payments or denials. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made.

SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Students Name: Last_____ First_____ MI_____
2. Date of Birth:_____ Social Security Number:_____ Sex: ❑ Male ❑ Female
3. Home Address: Street_____
   City_____ State_____ Zip_____
   Parent(s)/Guardian(s) Home Phone:_____
4. Date of Accident_____ Time of Accident_____ ❑ AM ❑ PM
   Nature of Injury_____
   Describe exactly how accident happened_____
5. Nature of activity and location during which the injury occurred (check all boxes which apply):

❑ Elementary or High School	❑ Cafeteria *Name of Sport, If applicable:*_____	
❑ Interscholastic Sports	❑ Intramural Sports	❑ Classroom Activities
❑ Club Sports	❑ Physical Education Class	❑ Other Activity (specify)_____
❑ During Practice	❑ During Play	❑ During Travel To or From the Event

   Nature of Your Participation:

❑ Student	❑ Decorating Committee	❑ Student/Manager
❑ Athletic Participant	❑ Cheerleader	❑ Band Member
❑ Other (specify)_____		

6. Transfer Student? ❑ Yes ❑ No
   If yes, please identify the school name:_____
7. Name, address and phone number of physician who first treated you:_____
   _____
8. Have you had a similar injury in the past? ❑ Yes ❑ No
   If yes, describe and give dates:_____
9. Name, address and phone number of physician who treated you for previous injury:_____
   _____
10. Are you covered by any other medical expense benefits plan? ❑ Yes ❑ No
    If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:
    _____
    _____
    _____

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief, the information contained is complete and correct as herein given.

I understand that it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s).

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance and/or Hartford Life Insurance Company or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Signature:_____ Date:_____

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS EXCESS MEDICAL COVERAGE.

THIS COVERAGE HAS A BENEFIT PERIOD OF 104 WEEKS FROM THE DATE OF THE ACCIDENT.

SECTION II – TO BE COMPLETED BY PARTICIPATING SCHOOL

FAILURE TO COMPLETE THIS FORM IN FULL MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Students Name: Last_____ First_____ MI_____
2. Social Security Number:_____
3. Date of Accident:_____
4. Activity:_____
5. Nature of Injury:_____
6. ❑ Left ❑ Right
7. Name of participating SCHOOL SYSTEM:_____
8. Name of participating SCHOOL:_____
9. I certify that all the foregoing statements and answers on this form are true and complete, and that this claim satisfies all criteria set forth in the ACCIDENT POLICY for proper consideration as a covered participant, covered activity and a covered condition, to the best of my knowledge and belief.

   SIGNATURE OF SCHOOL OFFICIAL:_____

   PRINTED NAME/TITLE:_____

   PHONE:_____ FAX:_____

   EMAIL:_____ DATE:_____